

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

**2.3 GUIDELINES FOR LAC DMH PSYCHIATRIC SERVICES PROVIDED IN  
MEDICAL EMERGENCY SETTINGS**

(Based on guidelines by the APA Task Force on Psychiatric Emergency Services)

January 2002

**I. OVERVIEW**

A. Comprehensive medical centers provide critical mental health services in medical emergency settings that cannot be duplicated elsewhere. LAC DMH works closely with the Department of Health Services to provide this level of care through the emergency rooms of the four major County Medical Centers: LAC+USC, Harbor/UCLA, Olive View/UCLA, and MLK/Drew. **DMH Service Goals** that can be met only in these settings include:

1. 24/7 geographical proximity for all county residents;
2. 24/7 availability for telephonic consultation with DMH clinical personnel;
3. 24/7 ability to accept and manage patients with any level of behavioral and medical instability;
4. 24/7 comprehensive assessment and stabilization for both psychiatric and general medical conditions;
5. 24/7 availability of urgent consultation from all medical specialty services; and
6. 24/7 ability to refer to appropriate levels of mental health care, from inpatient psychiatric units to outpatient clinical appointments.

B. DMH is committed to providing high quality services to all County residents. The APA Task Force on Psychiatric Emergency Services has developed guidelines for psychiatric services provided in medical emergency settings. DMH believes that conformance with such guidelines establishes an acceptable level of quality for such services. These guidelines, modified for specific applicability to DMH services, follow.

**II. ASSESSMENTS**

**A. Telephone Triage  
and Assessment**

1. Where this service is provided it must be performed by appropriately trained and credentialed licensed practitioners of the healing arts. (LPHA)

2. Staff should have completed training on telephone assessments, and there should be written guidelines for these assessments.
3. There must be a log of all calls received and the results of those calls that includes basic identifying information and an assessment of risk factors such as:
  - a. Risk of suicide or self-harm,
  - b. Risk of violence, and
  - c. Ability to care for self.

## **B. Screening Assessments and Processes**

1. Patients who present to a medical emergency room or department for psychiatric reasons should generally receive a full assessment. This is because the risk of adverse events, including suicide, is high in patients who are not adequately assessed.
2. If there are staff continuously available with psychiatric emergency experience and training (registered nurses with specific training in Psychiatric Nursing and two years experience, or board certified psychiatrists with appropriate experience and training in emergency psychiatry) then screening assessments with referrals to other services may be performed. See the section under Psychiatric Emergency Services below.
3. Patients should be continuously monitored until they are seen by a clinician trained to assess the risk of harm to self or harm to others.

## **C. Full Assessment**

Patients should almost always receive a full assessment to include:

1. **Psychosocial Assessment.** A suitably trained LPHA will perform a psychosocial assessment that will include:
  - a. A patient interview;
  - b. A review of records of past treatment (or documented efforts to obtain past records);
  - c. History gathering from collateral sources (provided that those sources who do not know that the patient is in the facility are not contacted without patient consent);
  - d. Contact with the current mental health providers wherever possible;
  - e. Identification of psychological, social, environmental and cultural factors that may be contributing to the emergency;
  - f. An assessment of the patient's ability and willingness to cooperate with treatment;
  - g. A structured assessment of risk factors relevant assessing

- risk for suicide or harm to others;
- h. A detailed assessment of substance use, abuse, and misuse;
- i. An assessment for possible abuse or neglect.

There will be explicit written criteria for the **training, experience and competence** of the LPHA in conducting these assessments. The criteria will specifically address competence in: identifying social, environmental and cultural factors that may be contributing to the emergency; assessing the patient's ability and willingness to cooperate with treatment; performing a structured assessment of risk factors; completing a detailed assessment of substance abuse; and assessing for possible abuse and neglect. The Director of the psychiatric emergency service will approve these criteria.

2. **Physician Assessment.** The physician in the emergency service with responsibility for the patient's care will:

- a. Perform an assessment of the patient's mental status that is adequate to pick up signs of a possible confusional state; and
- b. Complete an assessment of the patient (including a medical history, review of symptoms, physical evaluation, laboratory studies) that is adequate to rule out medical diseases that may have a similar clinical presentation.

When the LPHA and the emergency physician have completed their assessments they will discuss with each their findings.

#### **D. Written Protocols**

The consulting psychiatrist and the Director of the emergency service will approve a written protocol that specifies:

- 1. The circumstances under which the suitably trained LPHA and/or the physician in the emergency service should consult via phone with the consulting psychiatrist;
- 2. The criteria for the determination of the need and level of aftercare services; and
- 3. The process for the determination of eligibility criteria for involuntary treatment.

#### **E. Child Assessments**

Every patient less than 18 years of age shall have an assessment (including a developmental assessment) performed by a LPHA with appropriate training and experience in the assessment and treatment of children in a crisis setting.

#### **F. Laboratories**

There will be access to urgent (within four hours) urine toxicology screening.

**G. Staff Scope of Practice**

The Director of the psychiatric emergency service will approve the scope of practice for the LPHA involved in the assessment of patients.

**H. Coordination of Care**

A written policy will define the steps to be taken to ensure that every effort is made to contact existing treatment providers.

**III. TREATMENT PLANNING**

**A. Stabilizing Care**

1. There is access to immediate care to stabilize a behavioral emergency (e.g., to prevent harm to the patient or to others.)
2. There is a written protocol that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service. This protocol will be reviewed and approved by both the consulting psychiatrist and the Director of the emergency service and will be updated at least annually.

**B. Definitive Care**

Definitive treatment may not always be available in this care setting. Patients with a need for emergency psychiatric care will be referred to specialty psychiatric settings (e.g., inpatient services). Selected patients will be referred to outpatient psychiatric clinics or providers.

**IV. MEDICATION USE AND SAFE ACCESS TO APPROPRIATE MEDICATIONS**

**A. Access to Appropriate Medications**

There is immediate access to medications commonly used to treat acute psychiatric disorders and behavioral emergencies. This includes medications that are not on the facility's formulary but are commonly used in the community

**B. Dispensing and Storage of Medications**

All medications are securely stored and dispensed by appropriate staff. Patient medications are not used to provide treatment in the facility except in an emergency situation.

**C. Availability of Emergency Medications**

Emergency psychiatric medications are immediately available.

**D. Medication Administration**

1. Qualified staff administer medications.
2. Qualified staff assess the response to medications continuously during the first half an hour after administration and at least

very two hours thereafter.

## **V. SECLUSION AND RESTRAINT**

### **A. Staffing**

There are adequate numbers of staff available to ensure that when patients show signs of agitation there is immediate verbal intervention. Also, patients are not required to wait for food, water, or other necessities.

### **B. Staff Training**

All staff are continuously trained in alternatives to seclusion and restraint. This training is adjusted to reflect current quality improvement information about the use of seclusion and restraint. At least yearly each staff member receives a full day training in managing behavioral emergencies in the least restrictive, most effective, way.

### **C. Assessment of Patients in S&R (Seclusion & Restraint)**

1. Every time locked seclusion or restraint is performed it is based on the order of a physician.
2. Physicians perform an in-person assessment of each patient within one hour of seclusion or seclusion and restraint.
3. All patients in seclusion or seclusion and restraint are continuously observed by nursing staff.

### **D. Data Collection And Review**

1. Data regarding the use of seclusion and seclusion and restraint are collected and reviewed at least quarterly to identify opportunities for improvement in the management of S&R.
2. An annual comparison of the pattern and frequency of use of seclusion and restraint to that of at least two comparable facilities is conducted.
3. The results of this review are incorporated into staff training and the Quality Improvement process in a timely fashion.

## **VI. GUIDELINES FOR AFTERCARE**

- A. There are written guidelines to assist in the development of appropriate plans for ongoing treatment. There is a clear process outlined for referrals to other types and levels of care:
  1. Substance abuse facilities and providers;

2. Inpatient and outpatient mental health services.

- B. There is a written agreement with at least one of each of these types of services that formalizes the responsibilities of each agency in ensuring ongoing care.

## **VII. CONTINUITY OF CARE**

### **A. Discharge Process**

1. The discharge process ensures continuing care for patients with ongoing problems.
2. The service has developed a procedure for ensuring the availability of specific appointments (date, time, location) for outpatient mental health follow-up within one week of discharge.
3. Follow-up is a routine part of care. The service has a provision for following up with most patients after they are discharged (by phone or in person.)
4. The service routinely monitors its success with making aftercare plans that are most likely to be effective.

### **B. Security and Safety**

1. Security and safety needs in the service are evaluated on an ongoing basis and appropriate plans are implemented.
2. Provision is made for ensuring that there are no dangerous materials accessible to patients, including: sharp objects, weapons, materials that can be used for hanging, patient medications, etcetera.
3. The space is continuously supervised and monitored by staff.
4. There is controlled access to the space and a process of preventing elopement.

### **C. Waiting and Reception Areas**

Waiting and reception areas are comfortable and large enough to accommodate the patients and visitors.

### **D. Screening Assessment Area**

The area where patients wait for assessment is secure, with controlled access.

**E. Patient Privacy**

1. Private telephones are available for all patients.
2. Hallways may not be used for waiting and treatment areas.
3. Patient privacy is assured throughout the clinical assessment process.

**VIII. STAFFING****A. Staff Competence**

The competence of LPHA's is continuously evaluated, monitored and enhanced. There is a written procedure for ensuring the ongoing assessment of mental health staff competence in core clinical areas. This procedure is developed and approved by the Director of the psychiatric emergency service.

**B. Adequate Staffing**

There should be a consulting psychiatrist (s) available at all times by phone.

**C. Consultation and Continuous Learning**

Staff performance evaluation and review processes encourage all LPHA's to engage in continuous learning and skill development and to obtain consultation whenever they are uncertain about the appropriate course of action.

**D. Individual Assessment of Staff**

Every LPHA has an assessment completed at least yearly. The Director of the psychiatric emergency service participates in the process of assessing the LPHA's.

**IX. MEDICAL RECORDS**

A discharge plan is provided to the patient and to each agency providing aftercare for the patient.

**X. QUALITY IMPROVEMENT**

There is a continuous and active process of improving the quality of care. Staff participation in this process is a key aspect of performance evaluation.

## **XI. CRITICAL EVENTS**

- A. There is a process for reviewing other critical events: such as serious adverse events in the service, violence towards others after discharge, etcetera. This process includes, wherever possible, the clinical staff that were involved in the assessment and care of the patient.
- B. Findings from critical event reviews lead to changes in the way that care is provided.

## **XII. LEADERSHIP ROLES**

The Director of the psychiatric emergency service is a Board Certified psychiatrist with adequate training and experience in emergency and acute psychiatry.

## **XIII. ETHICS AND PATIENT'S RIGHTS**

- A. Treatment is not denied or delayed because of an inability to pay.
- B. As much as possible patients are involved in all aspects of making decisions.

## **XIV. CONSENT**

- A. All patients or their legal guardians give informed consent for treatment except those who are not competent to make these decisions.
- B. There is a written procedure that describes the evaluation of patients to determine if they are competent to give consent and that deals with the procedures for providing emergency care to such patients.

## **XV. CONFIDENTIALITY AND PRIVACY**

Confidentiality of all patients is maintained except:

- A. As permitted by law and as specified in written procedures



in order to ensure the safety of the patient or others.

- B. As permitted by law and as specified in written procedures in order to obtain information from health care providers.
- C. To the extent that the patient consents to the release of Information to others, especially significant others and health Care providers.

## **XVI. COMMUNICATION WITH SIGNIFICANT OTHERS**

- A. As much as is consistent with maintaining confidentiality (as outlined above) family members and other significant others are provided information about crisis and emergency treatment of psychiatric disorders and clinic procedures related to confidentiality.
- B. To the extent consistent with maintaining confidentiality and providing effective care, family members and other significant others are asked to provide information relevant to the clinical decision-making.
- C. Patients are asked about their wishes for involving significant others in clinical decision-making, and as much as possible, consistent with good quality of care and the patient's ability to understand the consequences of these decisions, those wishes are respected.

## **XVII. INFORMATION ON PATIENT'S RIGHTS**

- A. All patients are informed about patient rights in a language that they can understand. All patients are given written as well as verbal information about their rights.
- B. There is immediate access to an advocate who can provide additional information about patient rights to the patient. That advocate is independent from the administration of the service.

## **XVIII. COMMUNICATION WITH PATIENTS**

- A. There is a provision for communication with patients who are speech or hearing impaired.
- B. There is provision for interpretation in all languages

## **XIX. GRIEVANCE PROCESS**

Patients are adequately informed about the grievance process, and about any alternative means of expressing concerns or complaints about their care that may be available.